

September 13, 2019

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2406-P2
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2406-P2, Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Rescission

Dear Administrator Verma:

The undersigned national organizations, representing health care consumers and patients, providers, and other stakeholders, write to express serious concerns about the proposed rescission of this rule. Although we recognize there are concerns regarding the perceived administrative burden of the current regulatory requirements on states, we think it is misguided to rescind this rule without a clear replacement. **As such, we encourage you to withdraw CMS-2406-P2. We also offer comments for your consideration as CMS considers and develops a revised access monitoring process for the Medicaid program.**

As you know, Section 1902(a)(30)(A) of the Social Security Act requires states to assure payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers. The Medicaid Access Monitoring rule provides an important, if flawed, tool for CMS, states, and stakeholders to monitor access, consistent with 1902(a)(30)(A). Full rescission of the Medicaid Access Monitoring rule, without a replacement, would be a major setback to oversight and transparency. The Medicaid Access Monitoring rule contains provisions that help demonstrate levels of access to Medicaid services, and there are ways to modify rather than rescind the rule in order to reduce administrative burdens on states. We encourage you to reengage consumer representatives, providers, and states to pursue common ground on a reworked Medicaid Access Monitoring rule that can be beneficial to states, providers, and consumers.

We are particularly concerned with the disproportionate impact a rescinded rule would have on people of color, who make up approximately 60% of Medicaid enrollees, and other populations struggling with health and health care inequities.¹ Nationally, people of color are less likely to have access to a usual source of care,² despite being more likely to have a number of chronic conditions,³ and people of color with chronic conditions are less likely to have access to primary care.⁴ Racial and ethnic disparities also persist in the receipt of key preventive services, such as immunizations and cancer screenings,^{5,6} and people of color are more likely to live in communities designated as Health Professional Shortage Areas.⁷ The rescission of this rule, without a thoughtful replacement, holds the potential to exacerbate these inequities. Research clearly shows the importance of payment rates as it relates to provider participation in Medicaid. And without a mechanism for either federal administrative or federal judicial oversight, reductions in provider rates will push access to health care further out of reach for many Medicaid beneficiaries. It is imperative that CMS maintains a transparent and comprehensive oversight process that promotes equitable access to services and thereby promotes health equity. Weak federal oversight of access in the Medicaid program is a policy with distinct, foreseeable and troubling implications for justice in health care and in health outcomes.

However, we do believe that there are opportunities to design an access oversight process that makes sense for state Medicaid agencies and supports all stakeholders, especially Medicaid beneficiaries. Our comments below highlight key provisions we recommend under a reworked rule.

1. **Ensure Broad Transparency of Analyses Related to Rate or Methodology Changes:** Currently, § 447.203(b)(6), § 447.204(b), and § 447.204(c) require states to present CMS with an access analysis that accompanies any state plan amendment that reduces or restructures provider payments that could impact access. While these analyses can be difficult for states to conduct, it is a critically important question for states to answer. States must have an informed understanding of the potential impact of their proposed rate changes and be prepared to share that understanding. This analysis also allows states and CMS to monitor the actual impact against their hypothesis, consistent with Section 1902(a)(30)(A). Not only do we believe that § 447.203(b)(6), § 447.204(b), and § 447.204(c) should be maintained, we think they should also be expanded. Currently, these analyses are only available to CMS. The public should also have access to these critical analyses. While not necessarily a substitute for the triennial access monitoring review plan (AMRP), public availability of this data and a public input process would provide stakeholders with more immediate insight into the potential impact and rationale for the provider rate change.
2. **Better Align Medicaid Managed Care and Fee-for-Service (FFS) Access and Network Adequacy Requirements:** It is critical that we understand how individuals access Medicaid services, regardless of Medicaid delivery system. The Access Monitoring rule attempted to provide more insight into the FFS population, whereas the Medicaid managed care rule dictates state development of network adequacy standards for that population. The managed care rule on access and network adequacy, including maintaining time and distance, would be a good starting point for the development of a more aligned FFS standard.
3. **As part of alignment of Managed Care and Fee-For-Service Requirements, a National Standard for Access and Network Adequacy:** While it is important to allow states' flexibility in developing meaningful standards, we believe that there should be a national floor that ensures basic network adequacy, across and within all state Medicaid programs. This is a critical federal administrative responsibility under the *Armstrong* decision. In order to achieve this vision, we believe that CMS should engage state Medicaid agencies, consumer advocates, and providers in developing aligned and meaningful network adequacy requirements.
4. **Supplement Medicaid Claims/Administrative Data with Provider/Beneficiary Experience Data that Contributes to the Understanding of Access:** Much of the data required to comply with Medicaid Access Monitoring comes from claims or administrative sources. While it is administratively simpler for states to analyze their own data, claims and payment methodology data are not sufficient to provide a holistic picture of access. § 447.203(b)(4) primarily highlights the provider/beneficiary experience measures the state must analyze in their triennial Access Monitoring Review Plan. States should be required to establish systems to collect, analyze, and make public this information to contribute to our collective understanding of access in the Medicaid system.

Additionally, these analyses should be stratified by race and ethnicity, as well as the provider types listed in § 447.203(b)(5)(ii), as well as other key providers of interest such as medication

assisted treatment (MAT) and dental providers. Some of these variables are already included in the FFS access rule (e.g. time and distance standards; providers participating in Medicaid and/or not accepting new patients; service utilization trends and beneficiary needs; beneficiary and provider feedback; and availability of telemedicine). Building off of these variables, we believe it is important to also analyze:

- Appointment wait times;
- Distribution of providers;
- Transportation barriers;
- Language barriers; and
- Availability of extended hours.

We strongly oppose eliminating § 447.203(b) without a replacement that ensures a standard for collecting and analyzing these important components of access.

5. **Ensure Remedies are in Place for Deficiencies:** In order to make sure access standards are meaningful, CMS must have the authority to issue corrective action, when standards are not met. This proposed rule would eliminate § 447.204(d), which enumerates CMS' authority to remedy deficiencies. We strongly oppose removing the corrective action provision.

Thank you for your consideration of these comments. If you have any questions, please feel free to contact Joe Weissfeld, Director of Medicaid Initiatives at Families USA (202-626-0611 or jweissfeld@familiesusa.org).

Respectfully submitted,

Families USA
American Association on Health & Disability
American Nurses Association
American Podiatric Medical Association
American Speech-Language-Hearing Association
Center for Law and Social Policy
Center for Medicare Advocacy
Children's Dental Health Project
Children's Hospital Association
Coalition on Human Needs
Congregation of Our Lady of the Good Shepherd, U.S. Provinces
Cystic Fibrosis Foundation
Guttmacher Institute
National Advocacy Center of the Sisters of the Good Shepherd
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of Pediatric Nurse Practitioners
National Latina Institute for Reproductive Health
National Respite Coalition
National WIC Association
The AIDS Institute

¹ Kaiser Family Foundation. (2017). *Distribution of the Nonelderly with Medicaid by Race/Ethnicity*. Retrieved from: <https://www.kff.org/medicaid/state-indicator/distribution-by-raceethnicity-4>

² Agency for Healthcare Research and Quality (AHRQ). (May 2016). *National Healthcare Quality and Disparities Report: Chartbook on Access to Health Care*. Available at <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrd/chartbooks/access/qdr2015-chartbook-access.pdf>

³ Families USA. (January 2019). *Racial and Ethnic Health Disparities among Communities of Color Compared to Non-Hispanic Whites*. Available at: <https://familiesusa.org/product/racial-and-ethnic-health-inequities-among-communities-color-compared-non-hispanic-whites>.

⁴ Leyu Shi, Chien-Chou Chen, Xiaoyu Nie, Jinsheng Zhu, and Ruwei Hu. (2014). *Racial and Socioeconomic Disparities in Access to Primary Care Among People with Chronic Conditions*, *Journal of the American Board of Family Medicine* 27, no. 2: 189-198. Available at: <https://www.jabfm.org/content/27/2/189>.

⁵ X. Cheng, M. Lee, and R. Salloum. (2016). *Racial and Ethnic Differences in the Use of Preventive Services among Cancer Survivors in the Medicare Program*, *The Journal of the International Society for Pharmacoeconomics and Outcomes Research* 19, no. 3: A25-A26. Available at: [http://www.valueinhealthjournal.com/article/S1098-3015\(16\)00395-8/fulltext](http://www.valueinhealthjournal.com/article/S1098-3015(16)00395-8/fulltext).

⁶ Amanda Gelman, Elizabeth Miller, Eleanor Bimla Schwarz, Aletha Akers, Kwonho Jeong, and Sonya Borrero. (2013). *Racial Disparities in Human Papillomavirus Vaccination: Does Access Matter?*, *Journal of Adolescent Health* 53, no. 6: 756-762. Available online at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4058822/>.

⁷ Lydia Mitts and Sinsi Hernández-Cancio. (2016). *Dental Therapists Can Improve Access to Dental Care for Underserved Communities*. Available at: http://familiesusa.org/sites/default/files/product_documents/HE%26HST_DentalTherapist_Brief_web.pdf